

Insurance Carrier:

Texas Association of School Boards

(800) 482-7276 • (800) 580-6720 (Fax)

TWCC Claim # _____

Carrier's Claim # _____

Employer's First Report of Injury or Illness

1. Name (Last, First, M.I.)		2. Sex <input type="checkbox"/> F <input type="checkbox"/> M		15. Date of injury (m-d-yr)		16. Time of injury ____:____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		17. Date lost time began (m-d-yr)			
3. Social Security Number		4. Home Phone		5. Date of birth (m-d-yr)		18. Nature of injury		19. Part of body injured or exposed*			
6. Does the employee speak English? <input type="checkbox"/> yes <input type="checkbox"/> no If no, specify language				20. How and why injury/illness occurred*							
7. Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian		8. Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Native American		21. Was employee doing <input type="checkbox"/> yes his/her regular job <input type="checkbox"/> no		22. Worksite location of injury (stairs, dock, etc.)					
9. Mailing address (Street or P.O. Box)				23. Address where injury or exposure occurred Name of business if incident occurred on a business site Street or P.O. Box		County					
City		State		Zip Code		County					
10. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced				24. Cause of injury (fall, tool, machine, etc.)*							
11. Number of dependent children		12. Spouse's name		25. List witnesses							
13. Doctor's Name				26. Return to work date or expected (m-d-yr)		27. Did employee die? <input type="checkbox"/> yes <input type="checkbox"/> no		28. Supervisor's name		29. Date Reported (m-d-yr)	
14. Doctor's mailing address (street or P.O. box)				City		State		Zip Code			

30. Date of hire (m-d-yr)		31. Was employee hired or recruited in Texas? <input type="checkbox"/> yes <input type="checkbox"/> no		32. Length of service in current position ____ months ____ years		33. Length of service in occupation ____ months ____ years	
34. Employee payroll classification code		35. Occupation of injured worker					
36. Rate of pay at this job \$ ____ hrly \$ ____ wkly		37. Full work week is: ____ hours ____ days		38. Last paycheck was: \$ ____ for ____ hours or ____ days		39. Is employee an owner, partner, or corporate officer? <input type="checkbox"/> yes <input type="checkbox"/> no	

40. Name and title of person completing form		41. Name of business Conroe ISD									
42. Business mailing address and telephone number Street or P.O. Box		43. Business location (if different from mailing address) number and street 3205 West Davis									
City		State		Zip Code		City		State		Zip Code	
Conroe		Texas		77304-2098		Conroe		Texas		77304-2098	
44. Federal Tax Identification No. 746000556		45. Primary Standard Industrial Classification (SIC) Code* (4 digit) 8211		46. Specific SIC Code* (4 digit) 8211		47. Texas Comptroller Taxpayer No. 1-746000556					
48. Workers' Compensation Insurance Company Texas Association of School Boards				49. Policy Number 951							
50. Did you request accident prevention services in the past 12 months? <input type="checkbox"/> yes <input type="checkbox"/> no				If yes, did you receive them? <input type="checkbox"/> yes <input type="checkbox"/> no							
51. Signature and title (Read instructions on instruction sheet before signing)											
X _____ Date _____											